

ATTACHMENT 15

Sample Prior Authorization Dental Request Form (PA/DRF) for dental services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11035 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Dental Request Form (PA/DRF) Completion Instructions (HCF 11035A).

FOR MEDICAID USE — ICN	AT	Prior Authorization Number 1234567
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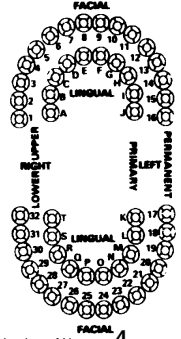
SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code) I. M. Provider 1 W. Williams St. Anytown, WI 55555	2. Telephone Number ? Billing Provider (XXX) XXX-XXXX	3. Processing Type (Check one) <input checked="" type="checkbox"/> 124 (Dental) <input type="checkbox"/> 125 (Ortho)
4. Billing Provider's Medicaid Provider No. 12345678		5. Performing Provider's Medicaid Provider Number

SECTION II — RECIPIENT INFORMATION

6. Recipient Medicaid ID Number 1234567890	7. Date of Birth — Recipient MM/DD/YYYY	8. Address — Recipient (Street, City, State, Zip Code) 609 Willow St. Anytown, WI 55555
9. Name — Recipient (Last, First, Middle Initial) Im A. Recipient		10. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Place of Service <input checked="" type="checkbox"/> Dental Office (POS 11) <input type="checkbox"/> Outpatient Hospital (POS 22) <input type="checkbox"/> Ambulatory Surgical Center (POS 24) <input type="checkbox"/> Skilled Nursing Facility (POS 31) <input type="checkbox"/> Other (please specify):						12. Dental Diagram <ul style="list-style-type: none">Circle periodontal case type if applicable: I <input checked="" type="radio"/> II III IV VCross out missing teeth.Circle teeth to be extracted.  Staple X-Ray Envelope Here	
13. Tooth No.	14. Procedure Code	15. Modifier	16. Description of Service	17. QR	18. Charge		
20	D3320		Root canal therapy bicuspid	1	XXX.XX		
11	D2932		Resin crown	1	XXX.XX		
19. Total Charges					XXX.XX		
20. SIGNATURE — Performing Provider <i>I.M. Provider</i>						21. Date Signed MM/DD/YY	
22. SIGNATURE — Recipient / Guardian (if applicable)						23. Date Signed	
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.						12. Dental Diagram Number of X-rays 4 Type of X-rays 2 BW, 2 PA	

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

<input type="checkbox"/> Approved	Grant Date	Expiration Date
<input type="checkbox"/> Modified — Reason:		
<input type="checkbox"/> Denied — Reason:		
<input type="checkbox"/> Returned — Reason:		

SIGNATURE — Consultant / Analyst

Date Signed